A Guide for Conducting Cultural Assessment of Hispanic and Latino Clients

National Hispanic & Latino

ATTC Addiction Technology Transfer Center Network

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Introduction

The ability of clinicians, counselors, social workers, and other behavioral health providers to conduct accurate assessments of Hispanic and Latino clients is very important. Understanding the role of culture, language, acculturation and stress should be considered part of the assessment process. This level of assessment can assist clinicians in understanding their clients beyond knowing about illness symptoms. Unfortunately, few behavioral health providers receive training to do cultural assessment. The result is that many of the Hispanic and Latino clients are not well understood and the issues that confront them are not addressed as part of the treatment planning process. Many Hispanic and Latino clients leave treatment prematurely as a direct result of the inability of providers to accurately assess cultural issues at the beginning of the treatment process. A small number of culturally tailored early intervention and treatment programs do exist and these programs rely heavily on cultural assessment and subsequent tailored treatment planning (see for example Santisteban & Mena, 2009).

The purpose of the *Guide for Conducting Cultural Assessment for Hispanic and Latino Client*s is to assist behavioral health providers who wish to augment and improve their assessment skills related to culture. The *Guide* can serve as a tool for training new clinicians and assisting experienced clinicians. The *Guide* provides specific templates and guidance on how to assess acculturation and related stress factors for both adults and adolescent clients and discusses how this level of assessment can be part of the cultural formulation and treatment planning process.

I. Epidemiology of behavioral health problems and disparities among Hispanic and Latino populations

Hispanic and Latinos are a diverse cultural group. Hispanic and Latino groups differ in national origin and history; in the particular social formations within each country that shape age, gender and class relationships; in the pressures within each country that have led to migration and the differing waves of migration. These features have not only created marked differences among the Latino groups, but considerable intra-cultural variation within groups as well (Guarnaccia, Martínez & Acosta, 2005). At the same time, changes within United States (US) society and cultures have affected where migrants have gone, how they have been received, the opportunities they have had to develop themselves as individuals and groups, and the cultures of the United States with which the migrants have interacted. Of all Latinos in the US, nearly 65% are of Mexican descent, making this group the largest subpopulation. People originating from Puerto Rico, Central America, and South America are the next largest subgroups (López, González-Barrera, & Cuddington, 2013). According to the US Census (2016) the projection of Hispanics in 2060 will be about 28% of the nation's total population.

Hispanics and Latinos often demonstrate a paradox with regard to mental health. Their rates of mental health problems are lower than for non-Hispanic Whites and lower than would be expected given their low socioeconomic status, exposure to social stress, ill-defined legal status among many immigrants and acculturation demands. According to Franzini, Ribble & Keddie (2001) for the past twenty years there has been widespread evidence of a Hispanic paradox in the United States, in which most Hispanic groups are characterized by low socioeconomic status, but better than expected health and mortality outcomes. Possible under-reporting of Hispanic deaths and healthy migrant effects, and risk profile may contribute to, but do not explain, the paradox. The reasons for this paradox are likely to be multifactorial and social in origin.

Traditional values toward family, strong sense of cultural identity and extended family supports are thought to mediate the negative impact of the social determinants of health noted above. Within Latino families, cohesion has been identified as a protective factor against external stressors (Hovey & King, 1996). The protective factor of family cohesion against distress has been considered a function of Latino families close knit relations, sharing sense of loyalty, reciprocity and solidarity among its members (Hovey & King, 1996).

At the same time, researchers have observed that the positive mental health status of Hispanics tends to erode with time spent in the United States. Acculturation is one possible explanation for the negative changes observed in mental health status (Ríos-Ellis et al., 2005). Acculturative stress, and stress experienced upon immigration to the US, has a pervasive, lifelong influence on Hispanic and Latinos' psychological adjustment, decision-making abilities, occupational functioning, and overall physical and mental health. Moreover, the majority of Hispanics and

Latinos expressing acculturative stress, and stress related to immigration, are influenced by many other factors including language barriers, deficits in coping resources, lack of cohesion with family members, and the short tenure of US residency.

Social support and traditional values tend to erode with greater exposure to American society, and risk factors such as increases in marital instability, low educational attainment, increased experimentation with drugs and alcohol, and changes in emotional support structures and gender roles all become more prevalent among Hispanics as they spend more time in the United States and begin to assimilate to American culture. Additionally, due to a range of academic barriers, a large share of Latino children and youth experience poor educational outcomes, resulting in decreased opportunities for employment and health care access, while contributing to high-risk behaviors that may contribute to poor mental health (Ríos-Ellis et al, 2005).

Substance Use and Mental Health Status of Hispanic and Latinos

In 2013, among persons aged 12 or older, the rate of current illicit drug use was 3.1% among Asians, 8.8% among Hispanics, 9.5% among whites, 10.5% among blacks, 12.3% among American Indians or Alaska Natives, 14.0% among Native Hawaiians or Other Pacific Islanders, and 17.4% among persons reporting two or more races (Substance Abuse and Mental Health Services Administration [SAMHSA, 2014]). Moreover, among Hispanics aged 12 and older, 43.0% reported current use of alcohol, while 24.1% of Hispanics youth reported binge alcohol use. Among Hispanic youth 12 to 17 in 2013, 20.7% reported current alcohol use. Rates of mental disorders for Hispanics or Latinos in 2012 include a 16.3% of people ages 18 and up reporting a past-year mental illness. About 4.4% of Hispanics or Latinos reported having had a serious mental illness in the past month. Hispanics also reported current major depressive episode rates of 7.0% and 3.4% reported a co-occurring mental health and substance use disorder.

Among Hispanics who needed but did not receive treatment in the past year, 95.8% did not feel the need for it, 2.2% felt the need for treatment but did not make an effort to get it, and 2.0% felt the need for treatment and did make an effort to get it. There are also differences in drug use within the Hispanic population as shown in Figure 1. For example, US born Mexican and Cuban Americans have the highest levels of any substance abuse disorder. Acculturation stress in likely to have different effects on individuals and families depending on unique, within ethnic differences on social support networks, as well as cultural norms and practices regarding alcohol and drug use (Alegría et al., 2008).

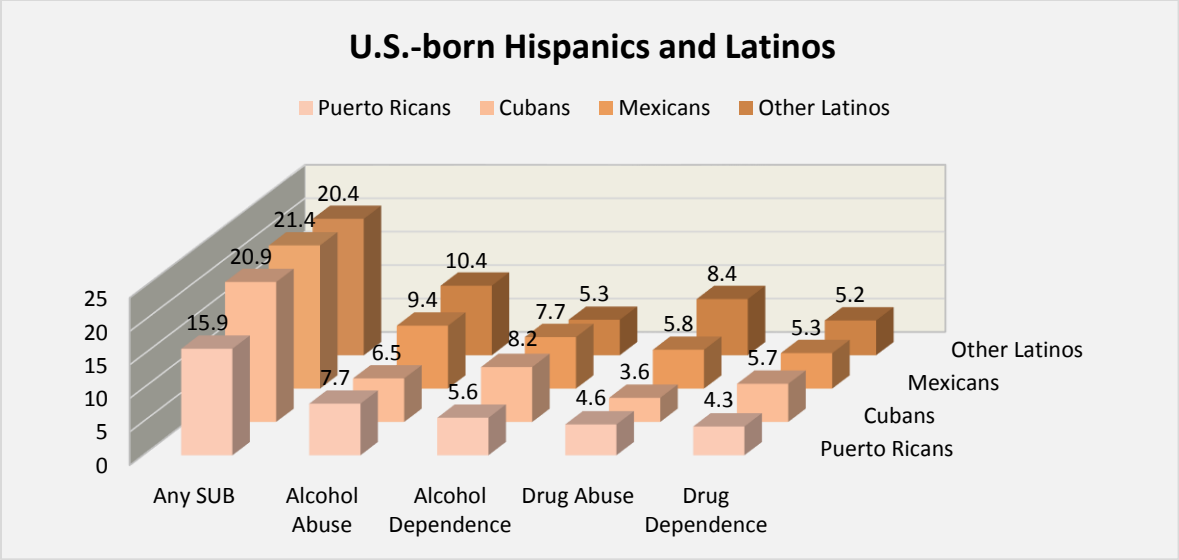

Figure 1: Hispanics/Latinos born in U.S and levels of substance abuse or dependence. (Alegría et al., 2008).

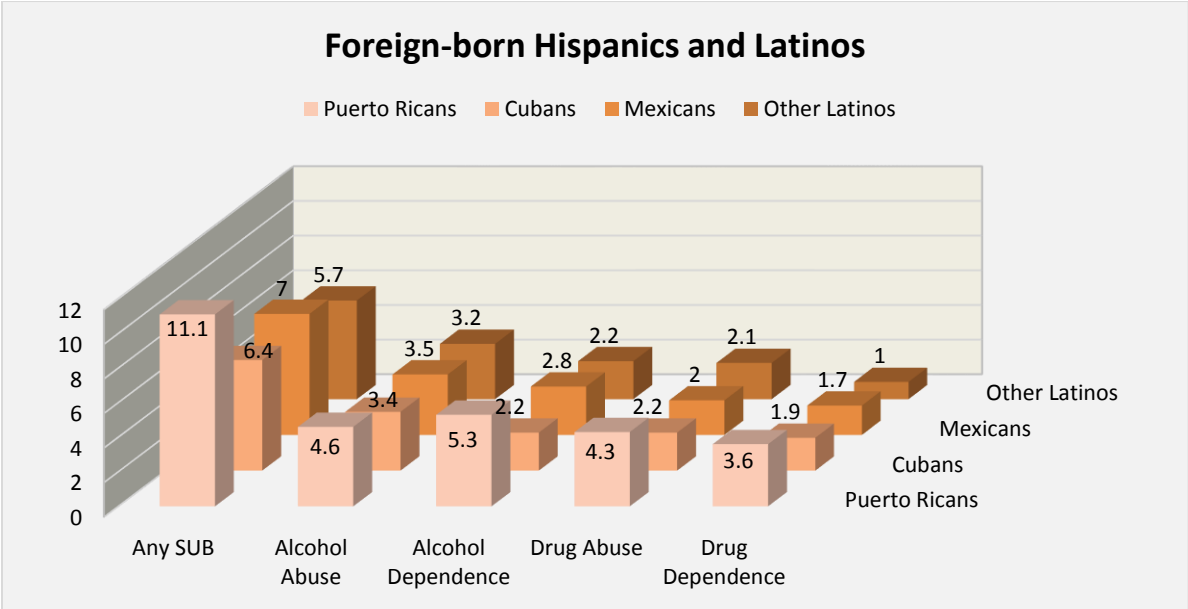

Figure 2: Hispanics/ Latinos born in a foreign countries and levels of substance abuse and dependence. (Alegría et al., 2008).

II. How and where do Latinos seek behavioral health and general health services?

The lack of health insurance and language barriers are the most commonly cited problems in Latino's utilization of mental health services (Escarce & Kapur, 2006). As seen in the chart below, Hispanics have a large percentage of the population that is uninsured.

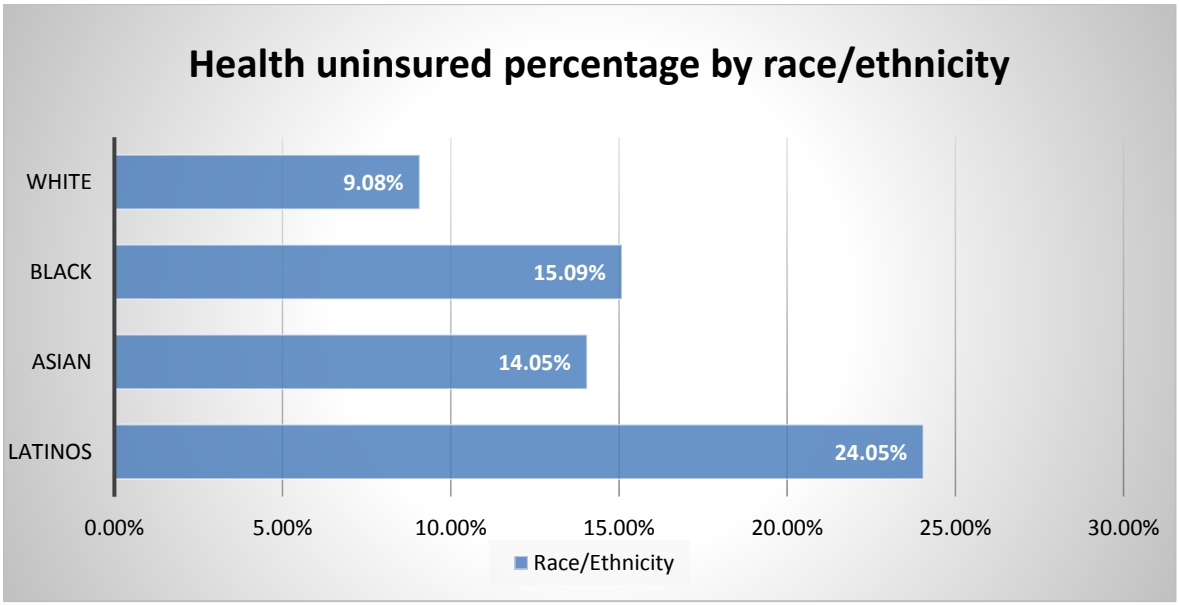

Figure 3: Health Uninsured Percentage by Race/Ethnicity, United States, 2013. (US Census Bureau, 2014).

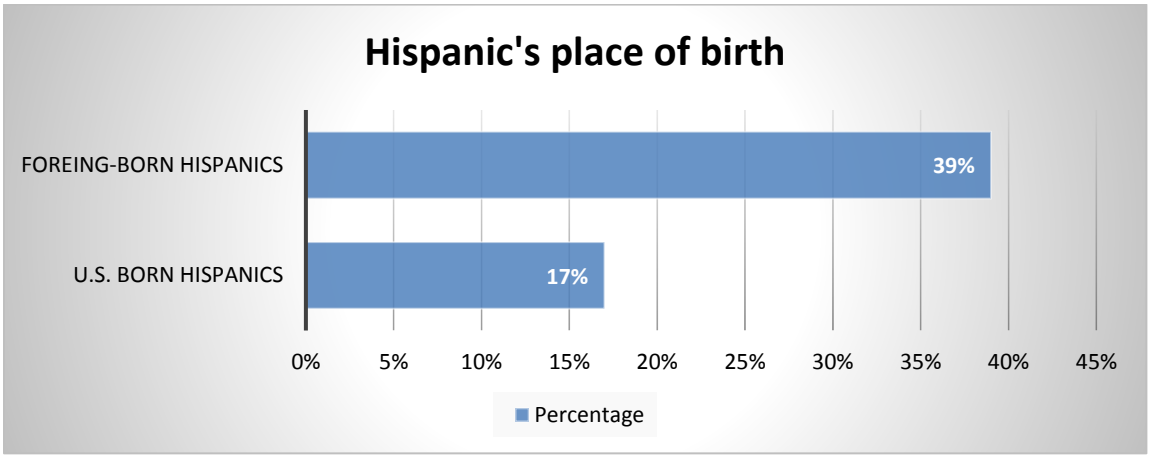

Figure 4: Hispanics/Latinos born place. (US Census Bureau, 2014).

For many Spanish-speaking Hispanics, finding mental health treatment from Spanish-speaking providers is very difficult. The percent of the total Hispanic population 5 years and over who spoke Spanish grew from 12.0% in 2005 to 12.9% in 2011, while the percentage who spoke Spanish and spoke English less than "very well" decreased from 5.7% in 2005 to 5.6% in 2011 (US Census Bureau, 2011). Immigrants are much less likely to use mental health services than US born Latinos. When Latinos do seek help for mental health problems, they are more likely to do so in the general medical sector than in specialty mental health services. Latinos are twice as likely to seek treatment for mental disorders in non-mental health settings, such as the offices of general health care practitioners or religious organizations. (Ríos-Ellis, et al., 2005). In one recent national health services survey, Dominicans (40%) and Puerto Ricans (40%) represented the highest proportion of non-elderly Hispanic males who had a usual place for preventive care. Thirty-five percent (35%) of non-elderly Mexican American, 30% of Central/South American, 30% of Cuban/Cuban American, and 24% of Mexican males had a usual place for preventive care (Office of Minority Health [OMH], 2015). Moreover, because of the lack of regular interface with health providers, many Latinos have little knowledge of their health care rights and what to expect in contemporary US health care settings.

Combined data from 2002 to 2007 indicates that an annual average of 8.3% (2.6 million) of Hispanics aged 12 or older were in need of alcohol treatment in the past year, and 3.4% (1.1 million) were in need of illicit drug use treatment (SAMHSA, 2013). Regarding Hispanics, the need for alcohol treatment was highest among Mexicans (9.2%), and the need for illicit drug treatment was highest among Puerto Ricans (6.1%). Among those in need of alcohol treatment in the past year, 7.7% received it in a specialty facility, and 15.1% of those in need of drug treatment received it in a specialty facility. Additionally, much of the existing evidence indicates disparities in access to and outcomes in substance use interventions for Latinos. For example, recent national surveys indicate that Latinos have less access than other Americans to substance use treatment or that they have to wait longer to access such services, and once they enter treatment they are less satisfied with the services they receive (Álvarez, 2007).

III. Unique clinical disparities among Latinos and cultural bound syndromes

Unique clinical disparities exist among Latinos. In particular, depression is pervasive among young Latinas and higher suicidal ideation when compared to other races and ethnicities (Ríos-Ellis, et. al., 2005). Women who immigrated recently to the United States and have to adjust to a new culture are more likely to have major depression than other women. Lack of acculturation, or adjustment to the new culture, may lead to problems because of issues like self-esteem and stress. High levels of acculturation among immigrants may lead to internalizing, or accepting, stereotypes (Duckworth, 2009). According to the US Census Bureau, 21.5% of Latinos live below the federal poverty line, compared with 8.2% of Whites (US Census, 2014). Poverty also contributes to the higher rates of depressive symptoms. Only about 21.0% of Latina women seek mental health help and/or treatment. Other risk factors may include racial/ethnic discrimination, low-status and high-stress jobs, unemployment, poor health, larger family sizes, divorce or separation and single parenthood (Duckworth, 2009). Strong feelings of perceived and real prejudice part of ethnic family cultures also play role. The emotional strain of caring for elderly parents can also be a risk factor for depression in Latinas.

In the United States, 10.7% of adolescents aged 12-17 (an estimated 2.6 million adolescents) in 2013 had at least one Major Depression Episode (MDE) within the year prior to being surveyed (SAMHSA, 2014). The percentage age of MDE among US adolescents was about 3 times higher among females (16.2%) than among males (5.3%). Also, nationwide 17.0% of students had seriously considered attempting suicide during the 12 months before the survey (Kann, et al., 2014). The prevalence of having seriously considered attempting suicide was higher among female (22.4%) than male (11.6%) students; higher among white female (21.1%), black female (18.6%), and Hispanic female (26.0%) than white male (11.4%), black male (10.2%), and Hispanic male (11.5%) students, respectively. The prevalence of having seriously considered attempting suicide was higher among Hispanic (18.9%) than white (16.2%) and black (14.5%) students and higher among Hispanic female (26.0%) than white female (21.1%) and black female (18.6%) students (Kann et al., 2014). Moreover, in 2013, the percentage age of adults who had serious thoughts of suicide and serious mental illness was higher among those without health insurance and among those living in households whose income was less than 100% of the Federal Poverty Level.

In addition to major depressive episode and suicide ideation and attempts, Latinos may often present with cultural bound syndromes (Bayles, & Katerndahl, 2009). A culture-bound syndrome denotes recurrent, locality-specific patterns behavioral problems and troubling experiences that may or may not be linked to a particular Diagnostic and Statistical Manual (DSM-5) diagnostic category. Many of these patterns are indigenously considered to be "illnesses," or at least afflictions, and most have local names. For Latinos, local names include *susto, empacho, nervios, mal de ojo,* and *ataques de nervios*. Culture-bound syndromes are generally limited to specific societies or culture areas and are localized, folk, diagnostic categories that frame coherent

meanings for certain repetitive, patterned, and troubling sets of experiences and observations (Kramer & Lu, 2009).

In the context of psychiatric disorders, cultural influence is evident at multiple levels. First, culture and society shape the meanings and expressions people give to various emotions (Kleinman, 1985). Second, cultural factors determine which symptoms or signs are normal or abnormal (Kirmayer, 1984). Third, culture helps define what comprises health and illness (Al Busadi, 2010). Finally, it shapes the illness behavior and help seeking behavior (Devins, 1999). So, it would not be erroneous to conclude that cultural influence on psychiatric disorders includes conditions other than Cultural Bound Syndrome.

In an effort to improve diagnosis and care to people of all backgrounds, the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) incorporates a greater cultural sensitivity throughout the manual. Rather than a simple list of culture-bound syndromes, DSM-5 updates criteria to reflect cross-cultural variations in presentations, gives more detailed and structured information about cultural concepts of distress, and includes a clinical interview tool to facilitate comprehensive, person-centered assessments (American Psychiatric Association, 2013).

IV. Assessing and integrating level of acculturation into treatment planning

Rudmin (2009), in a review and critique of acculturation measures, defines acculturation as "second-culture acquisition". Rudmin suggests that much of the past research on acculturation has mistakenly equated acculturation with negative stereotypes about minority groups and prefers to think about acculturation as a process of cultural learning. Such cultural learning often involves adapting to a new language, new customs and social practices, and does not require that one's culture of origin be abandoned.

Measuring and assessing a client's level of acculturation and learning about problems, barriers or challenges the client may have in acquiring a second culture are very important in the assessment phase of counseling and treatment. It is important to consider measuring acculturation in a health context because it contributes to our understanding of the economic, social, and health care needs of Hispanic residents (Wallace et. al 2010).

Assessment of acculturation can include measuring the degree to which a client a) has acquired aspects of the new culture (e.g., American culture), b) the degree to which the client maintains his/her own language and cultural orientation, and c) the client's ability to easily function in both the new culture and culture of origin (bicultural). More recent research, using latent class analysis (Schwartz & Zamboanga, 2008) found that classes resembling three of John Berry's (Berry, 1991) original acculturation categories — integration, separation, and assimilation — emerged from analysis, along with two additional variants of biculturalism and an extremely small class resembling the marginalization category. In addition, Schwartz, Unger, Zamoanga, and Szapoznik (2010), highlight the importance of language and country of origin as important aspects of measuring acculturation.

The importance of recognizing that acculturation is a multidimensional process has been emphasized in the work of Schwartz, Unger, Zamboanga & Szapoznik (2010). No longer can we simply say that a client has "high acculturation" or "low acculturation". Others (Marino, et al., 2001) have similarly suggested that measuring acculturation should differentiate between psychological processes (e.g., attitudes, values, preferences, loyalties) and behavioral changes (e.g., language, customs, food preferences). Bidirectional assessment of acculturation consists of measuring two distinct independent dimensions, adherence to the dominant culture and maintenance of the culture of origin.

Hispanic clients often have clear preferences about their desired acculturation orientation and language and therefore counselors must assess, measure or inquire about these very personal cultural preferences. There are numerous acculturation measures available for counselors who work with Hispanic clients. Measures have been developed for both youth and adults. As an example, Freeman, Lewis and Colón (2002) identified 17 scales to measure acculturation among

Hispanics. One of the more widely used is the Acculturation Rating Scale for Mexican Americans-II (ARSMA-II; Cuellar, Arnold, & Maldonado, 1995) which was developed as a multidimensional assessment to measure levels of acculturation in Mexican-Americans. Marín and Gamba (1996) developed the Bidirectional Acculturation Scale (BAS), and more recently, in selecting an acculturation measure, counselors should ensure that the measure:

- is easy to administer;
- is available in Spanish;
- measure both psychological processes and behavioral changes;
- scoring and interpretation that can be incorporated into treatment planning.

V. Assessing psychosocial and cultural stress as risk factors among Hispanic and Latino adults

Why do clinical assessment?

Clinical assessment, sometimes referred to as diagnostic assessment, is a necessary and critical component to understanding the client's needs, motivations, traumatic experiences and goals. Clinicians and counselors often rely on basic client intake forms that serve as a guide for gathering client history and behavioral health symptoms. In some cases, trained psychologists may be asked to do more in-depth interviews and administer standardized psychological testing to determine cognitive functioning and the degree of psychological impairment and symptoms. Also, in some cases, a psychiatrist may also conduct an assessment of more severe mental illness and the need for psychotropic medication to alleviate severe symptoms and impairment. Comprehensive clinical assessment is required to develop accurate diagnosis and subsequent treatment planning for both adult and youth clients who enter behavioral health care. Assessment and documentation of clinical diagnoses and level of functional impairment are now often required by payers of behavioral health services.

What do we know about conducting assessments with Hispanic and Latino clients?

Behavioral health assessments, procedures, and tools to facilitate detection and accurate diagnosis for Hispanics seeking care are limited (Cervantes & Bui, 2015; Cervantes & Acosta, 1992; Cervantes, Fisher, Córdova, & Kilp, 2011; Malgady & Zayas, 2001). Unfortunately, many psychological assessment tools for Hispanics today are still limited to translations of existing clinical and research measures that are not normed on appropriate Hispanic populations (Cervantes & Acosta, 1992; Yamada, Valle, Barrio, & Jeste, 2006). Instead, according to Cervantes and Bui (2015) and Rodríguez (1992); assessments of how Hispanics perform on psychological tests are generally developed, validated and standardized on a non-minority, White, middle-class population. The lack of reliable and valid tests normed on samples of Hispanics populations, both Spanish-speaking and English-speaking, is a significant obstacle in the overall assessment of Hispanics (Bird et al., 1988; Loewenstein et al., 1994; Velasquez et al., 1998). Psychological testing can also be affected by many factors, especially language and cultural factors. Several studies found that language ability, level of acculturation as well as socioeconomic issues must be taken into consideration when providing assessments to Hispanic populations (Schwartz, Unger, Zamboanga & Szapoeznik, 2010). To date, few measures have been developed and disseminated specifically tailored to the contexts of the Hispanic population. In addition, as mentioned above, research has made it evident that Hispanics, in response to stressful events, may manifest symptoms that are culturally bound, Culture Bound Syndromes, such as *susto* (fright), *mal de ojo* (evil eye) and *nervios* (nerves) or ataque de nervios (Guarnacia, Canino, Rubio-Stipec, & Bravo, 1993; Guarnacia, Lewis- Fernández, & Rivera-Marano, 2003).

Assessing acculturation stress is important

As a group, many Hispanics are exposed to particularly stressful circumstances. For example, recent studies conducted by the Pew Hispanic Research Center (López & Velasco, 2011) show that of the 6.1 million Latino children living in poverty, more than two-thirds (4.1 million) are the children of immigrant parents. Hispanics also experience stress related to discrimination, parent-child cultural conflict, and family separation due to immigration (Cervantes & Bui, 2015; Taylor & Seeman, 1999). The acculturation process itself may best be framed within a stressful life-events paradigm (Rudmin, 2009). This theory that postulates that social organization plays a significant role in the origins and consequences of stressful life experiences (Aneshensel, 1992). Further, Lazarus and Folkman (1984) articulated the concept of stress appraisal, which is the subjective (negative) psychological reaction to a specific stress event or set of events. Similarly, negatively appraised stressor events related to acculturation within the Hispanic population are an important antecedent for mental health problems in both adults and children (Berger-Cardoso, et. al, 2016; Rogler, Cortes, & Malgady, 1991; Vega & Gil, 1998). Berry (1991) described "acculturation stress" as the result of one's culture of origin interacting with host culture values, attitudes, customs, and behaviors. Individuals and families from one cultural orientation who are constantly being exposed to new, novel, and challenging events and situations require some form of psychological and behavioral adjustments. Exposure to racial or ethnic discrimination (negative behaviors toward Latino youths) can constitute a source of daily stress (Romero & Roberts, 2003). As part of the cultural assessment to assess levels of acculturation stress, counselors can also explore and assess the role of coping among their clients. How are coping strategies used? What coping strategies are absent? How can counselors help clients to "mobilize" healthy coping strategies, including the use of cultural protective factors?

VI. Assessing protective factors among Hispanic and Latinos

Protective factors are conditions or attributes in individuals, families, communities, or the larger society that, when present, mitigate or eliminate risk in families and communities imply defined, "factors associated with greater potential for drug abuse are called "risk" factors, while those associated with reduced potential for abuse are called "protective" factors" (NIDA, 2003). Some of the factors identified as protective include involvement of parents in the student's life, family values and connectedness, academic success, involvement in extracurricular activities, connections with institutions such as school, college based organizations, religious organizations, and accepting traditional norms against drug abuse (NIDA, 2003). Although the NIDA document is geared toward children and adolescents, research has shown that some of these general protective factors, such as familial values and attitudes toward alcohol use, can also be connected to reducing the risks associated with heavy drinking within the college-aged population (Hawkins, Catalano, & Arthur, 2002).

Assessment of the protective factors that are present in clients or families that enter treatment is an important aspect of the initial diagnostic and treatment planning phase. This Guide will provide an outline for assessing not only acculturation related stress factors that contribute to behavioral health problems, but also helping counselors to determine the presence of culturally based and other protective factors that can be mobilized during the treatment process.

Culture as a Protective Factor

Although a diverse group, Hispanics are believed to maintain a set of shared cultural values, some or all of which may have a positive health relevance and may be considered protective factors. For example, Marín and Marín (1991) have described seven core Hispanic cultural values, including allocentrism, *simpatía*, *famililsmo* or power distance, personal space, orientation, and gender roles. Allocentrism and *familismo* are overlapping cultural factors that reflect a collective view in which the needs and objectives of the group or family are placed over the specific needs of the individual and strong attachments to the nuclear and extended family are emphasized. *Simpatía*, on the other hand, reflects a drive toward pleasant and non-confrontational social interactions that leads to avoiding interpersonal conflict and may foster socially desirable patterns and responses. Marin and Marin define the concept of personal distance as the appropriate amount of physical space deemed appropriate in interpersonal interactions, with Hispanics exhibiting greater comfort with close distances. Traditional gender roles within the Hispanic culture suggest a pattern of male dominance (*machismo*) and female submissiveness (*marianismo*) and the extent to which any of these cultural values is associated with health outcomes is not well understood.

Research findings, however on the role of some of these cultural factors as being protective, is still lacking. For example, *familismo* and allocentrism may provide a strong social support network with its associated benefits in the context of adverse circumstances. However, these constructs may also negatively influence Hispanics' willingness to adopt positive drug use or HIV related behavioral and health changes they do not perceive to directly benefit their nuclear and extended family or may discourage disclosure of information on sexual orientation that may compromise personal respect (Marín & Marín, 1991). While *simpatía* may minimize exposure to interactions involving conflict and confrontation, this cultural value may also prevent beneficial, proactive engagement in interacting with the complexities of the medical system. The extent to which cultural variations in attitudes and behavior exert harmful or protective influences on health status remains to be determined (Rodríguez, 1995).

Most studies of psychosocial outcomes related to *familismo* do find favorable psychosocial results for Hispanic children (Calderón-Tena et al., 2011; Morcillo et al., 2011), adolescents (Esparza & Sánchez, 2008; Germán, Gonzáles & Dumka, 2009; Kuperminc, Wilkins, Jurkovic & Perilla, 2013; Marsiglia, Parsai & Kulis, 2009). Incorporating Latino family values into early intervention and prevention programs can buffer the impact of weakening connection to traditional family protective factors (Castro & Alarcón, 2002).

Other potential protective factors have been identified (Cervantes & Santisteban, 2016) and these relate strategies should be explored and possibly mobilized for some client:

- Sense of Cultural Pride/Ethic Loyalty
- Bilingualism
- Spirituality/Religion
- Information seeking
- Reliance extended family

VII. Guidelines for cultural assessment

How were these guidelines developed?

The Guidelines and Assessment Worksheets presented here are based on Latino adolescent and adults research that has identified risk domains or "clusters" of personal, family and environmental stressors specific to Latinos. Evidence-based assessment domains have been developed from studies on acculturation stress among Hispanic and Latino youth and adults. Each of the clusters of risk factors has been validated and have been shown to be related to other mental health indicators, including depression, anxiety, somatic problems and substance use among adolescents (Berger-Cardoso, Goldbach, Cervantes & Swank, 2016; Goldbach, Cardoso & Cervantes & Duan, 2015; Cervantes, Berger Cardoso & Goldbach, 2014). The Guidelines also are based research to develop both the Hispanic Stress Inventory for Adolescents (HSI-A) and the Hispanic Stress Inventory – Version 2 (HSI2; Cervantes et al., 2011; Cervantes et al., 2015).

The Hispanic Stress Inventory for Adolescent (HSI-A), is a culturally informed stress assessment specifically tailored to Hispanic adolescents. The assessment is composed of 71 items arranged within 8 domains. Findings from a national survey study (Cervantes, Fisher, Córdova & Napper, 2011) suggest that appraisals of stress as measured by the HSI–A are associated with higher levels of symptoms related to psychopathology and behavioral and conduct problems, as well as higher levels of emotional disturbance among youth participants.

The HSI–A, when compared with other assessment measures, has the ability to screen for culturally based stressor events such as acculturation gaps, family immigration stress, and discrimination stress. As such, culturally informed early screening and assessment with tools such as the HSI–A may prove beneficial to school personnel, as well as to trained clinicians who desire more relevant diagnostic information for treatment planning purposes.

For adults, the Hispanic Stress Inventory – Version 2 (HSI2) was developed using a national sample of Hispanic adults in 4 large U.S. cities. The immigrant version of the HSI2 includes 10 stress subscales, while the US-born version includes 6 stress subscales. Both versions of the HSI2 are shown to possess satisfactory Cronbach alpha reliabilities and demonstrate expert-based content validity, as well as concurrent validity when correlated with subscales of the Brief Symptom Inventory and the Patient Health Questionnaire. The new HSI2 instruments are recommended for use by clinicians and researchers interested in assessing psychosocial stress among diverse Hispanic populations of various ethnic subgroups, age groups, and geographic location. For the purpose of the Guide, a global Assessment Worksheet that includes risk factors for both US-born Hispanics and immigrants has been provided. In addition to helping counselors identify acculturation-related stressors, the Guideline and Assessment Worksheets provide the counselor with a framework to identify individual, family and community protective factors that are present in each client or family and that can be mobilized as part of the treatment process.

Who should use the guidelines? What is the necessary skill level?

The following Guidelines can be used in an interview setting and should be conducted by trained behavioral health services clinical or intake staff. In the event that the client is mono-lingual Spanish speaking, Spanish speaking clinical staff are recommended. The assessment guidelines can be used by non-Spanish speaking clinical staff if qualified translation services are available. Language access and preference is important to Spanish-speaking clients. Agencies who have bilingual staff or interpreters can serve individuals seeking and engaging in treatment services that meets or surpasses the new enhanced federal Culturally and Linguistically Appropriate Services (CLAS) Standards (US Department of Health and Human Services, 2013). CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services.

When should these guidelines be applied?

The Guidelines can be used in conjunctions with other standardized intake and assessment history taken and treatment planning activities. Information drawn from the following assessment Guidelines can also be used in conjunction with diagnostic psychological testing, as well as DSM 5 Cultural Formulation procedures. The Guidelines should be used during the initial intake and assessment period, usually done in the first 1-3 weeks of the treatment process. The Guidelines may also be used to augment assessment procedures that may be included along with assessments for evidence-based programs and practices.

Guidelines for Hispanic adolescent assessment

The following Assessment Worksheets provide a brief description of each of the stress/risk domains as well as the areas of assessment to be covered within each domain. After developing rapport with the adolescent client, the clinician/counselor can begin with Assessment Domain 1 and proceed to Assessment Domain 7. A general Assessment Question is followed by inquiry about specific risk factors within each Domain. For example, if the youth client reports high levels of stress and conflict with parents regarding Acculturation Gaps, a richer discussion within that Domain can be guided by using specific stressor questions (e.g., Parents upset that I wanted to date outside my race/ethnicity).

Suggestions for Treatment Planning

For each Assessment Worksheet Domain, the clinician/counselor should not only assess risk Domains and specific stressors, but can also use the following Worksheet tables to identify specific protective factors and can develop ideas for helping the client "mobilize" these coping resources and protective factors.

Assessment Step 1: Determine if the client has significant stress or trauma in the Domain represented in each Worksheet. A general question about overall stress levels is included in each Worksheet.

Assessment Step 2: If it is determined by the counselor/clinician that there are moderate or high levels of stress risk, a set of specific cultural stressor/risks can be assessed. These are listed in each of the Worksheets and can be used as a point of further inquiry and discussion with the client.

Assessment Step 3: For each Domain, once specific clusters of cultural stress can be identified for the client, the counselor/clinician should attempt to identify strengths and resources that can be mobilized to help the client develop a coping strategy. These strategies can become part of the treatment plan.

Assessment Step 4: Re-Assessment of overall cultural risk/stress can be conducted using the Worksheets and the Domain specific stressors. The re-assessment can be conducted periodically through the treatment process and will assist counselors/clinicians in keeping the treatment tailored, with an emphasis on cultural risk/stress factors.

HISPANIC ASSESSMENT WORKSHEETS FOR ADOLESCENTS

Client Name _____
Age _____
Date of Assessment _____

Domain 1. Family Economic Stress, reflects family financial struggles, including problems paying bills and having access to medical care.			
"Overall how much stress do you or your family have regarding financial issues?"	*High*	*Moderate*	*Not a problem*
If High or Moderate, Counselor should probe further using the following areas			
Family could not afford medications			
Family struggled paying bills			
Family had problems paying rent			
Family could not afford to pay doctors			
Not enough money for everyone in family			
Could not afford to buy good clothes			
Money problems interfered with school			
Could not afford to move			
Parents could not get a good job			
Family's needs came before my needs			
No money to plan for college			
Money problems made me want to leave school			

What resources area available for this youth?

How can resources be mobilized as part of the treatment plan?

Domain 2. Culture and Educational Stress, includes stress experienced due to Hispanic culture not being recognized at school and to racial tensions at school.			
"Overall, how much stress do you or your family have related to cultural conflicts at your school?"	*High*	*Moderate*	*Not a problem*
If High or Moderate, Counselor should probe further using the following areas			
People were suspicious of me when I spoke Spanish			
Racial tensions at school			
Had to translate personal information for parents			
School ignored cultural history			
Latinos at school not accepted			
Teachers think I am cheating when I am speaking Spanish			
Arguments with non-Hispanic students			
Customs and holidays not recognized at school			
Family members were rejoined			
Negative stereotypes of Latinos in neighborhood			
Ridiculed because of clothes			
Did not mix with other cultures/races			
Embarrassed because parents do not speak good English			
Things taught at school irrelevant to me			

What resources area available for this youth?

How can resources be mobilized as part of the treatment plan?

Domain 3. Acculturation-Gap Stress, includes items assessing intercultural and intergeneration conflict.			
"Overall, how much stress do you and your parents have related to cultural conflicts and the way your parents think about you, the rules they want you to follow?"	*High*	*Moderate*	*Not a problem*
If High or Moderate, Counselor should probe further using the following areas			
Parents overprotective			
My parents were too traditional			
Parents did not understand me			
Parents disapproved of friends			
Parents want me to maintain customs and traditions			
No privacy at home			
Parents upset that I wanted to date outside my race/ethnicity			
Broke up with boyfriend/girlfriend			
Parents used different rules for daughters/sons			
Expected to do many chores at home			
Forgot some Spanish			
Expected to be like a parent to siblings			

What resources area available for this youth?

How can resources be mobilized as part of the treatment plan?

Domain 4. Immigration-Related Stress, reflects personal experiences of stress due to immigration.			
"Overall, how much stress do you or Your Family have related to Immigration Problems?"	*High*	*Moderate*	*Not a problem*
If High or Moderate, Counselor should probe further using the following areas			
We left close friends in home country			
Thought about life in home country			
Hard leaving people in home country			
Separated from some family members			
Had to leave family behind in home country			
Members of family "homesick"			
Learning English was a struggle			

What resources area available for this youth?

How can resources be mobilized as part of the treatment plan?

Domain 5. Discrimination Stress, includes experiences of racism, bullying and otherwise being disrespected at school.			
"Overall, how much stress do you or your Family have related to discrimination problems?"	*High*	*Moderate*	*Not a problem*
If High or Moderate, Counselor should probe further using the following areas			
Students made racist comments to me			
Students said racist things about me			
I was Picked on by other students			
I was Pointed at and called names			
I am Not liked because of my physical looks (skin color; hair)			
I was Disrespected by other students			

What resources area available for this youth?

How can resources be mobilized as part of the treatment plan?

Domain 6. Family Immigration Stress reflects stress due to legal problems experienced by family members when immigrating.			
"Overall, how much stress do you or your family have related to immigration problems that affect other family members such as aunts, uncles, cousin, grandparents?"	*High*	*Moderate*	*Not a problem*
If High or Moderate, Counselor should probe further using the following areas			
Family afraid of getting caught by immigration officials			
Family had problems with immigration papers			
Family had problems finding work after migrating			
Family had to pay a lot of money to migrate			
Family was caught when migrating			
Family was forced to migrate			
Family started all over after migrating			

What resources area available for this youth?

How can resources be mobilized as part of the treatment plan?

Domain 7. Community and Gang-Related Stress, includes issues relating to both personal experiences of violence and gangs and stress related to violence in the community.			
"Overall, how much stress do you or your family have related to gangs or community safety problems?"	*High*	*Moderate*	*Not a problem*
If High or Moderate, Counselor should probe further using the following areas			
A lot of pressure to get involved with gangs			
Neighborhood dangerous			
Saw drive-by shooting			
Boyfriend/girlfriend in gang			
Involved in physical fights			
Stereotyped as a gang member			
Saw weapons at school			
Fought with other students			

What resources area available for this youth?

How can resources be mobilized as part of the treatment plan?

Domain 8. Family and Drug-Related Stress, reflects stress associated with violence and drug use in the family.			
"Overall, how much stress do you or your family have related to substances problems?"	*High*	*Moderate*	*Not a Problem*
If High or Moderate, Counselor should probe further using the following areas			
Violence in family			
Family member sold drugs			
Family member had a drug problem			
Too little contact with parents			
Hard to speak with family			

What resources area available for this youth?

How can resources be mobilized as part of the treatment plan?

Guidelines for Hispanic adult assessment

The following Assessment Worksheets are to be used as part of the initial screening and diagnostic process. The Worksheets provide a brief description of each of the stress/risk domains as well as the areas of assessment to be covered within each adult stress risk domain. After developing rapport with the adult client, the clinician/counselor can begin with Assessment Domain 1 and proceed to Assessment Domain 7. A general Assessment Question is followed by inquiry about specific risk factors within each Domain. For example, if the client reports High levels of stress and conflict within the Discrimination domain, a richer discussion within that Domain can be guided by using specific stressor questions (e.g., I was discriminated against in the health clinic or hospital).

Suggestions for treatment planning

For each Assessment Domain the clinician/counselor should not only assess risk Domains and specific stressors, but can also use the following tables to identify specific protective factors and can develop ideas for helping the client "mobilize" these coping resources and protective factors. The following tables provide a brief description of each of the stress/risk domains as well as the items within each domain.

Assessment Step 1: Determine if the client has significant stress or trauma in the Domain represented in each Worksheet. Definitions of each Domain are included in the Worksheet. A general question about overall stress levels is included in each Worksheet.

Assessment Step 2: If it is determined by the counselor/clinician that there are moderate or high levels of stress risk, a set of specific cultural stressor/risks can be assessed. These are listed in each of the Worksheets and can be used as a point of further inquiry and discussion with the client.

Assessment Step 3: For each Domain, once specific clusters of cultural stress can be identified for the client, the counselor/clinician should attempt to identify strengths and resources that can be mobilized to help the client develop a coping strategy. These strategies can become part of the treatment plan.

Assessment Step 4: Re-Assessment of overall cultural risk/stress can be conducted using the Worksheets and the Domain specific stressors. The re-assessment can be conducted periodically through the treatment process and will assist counselors/clinicians in keeping the treatment tailored, with an emphasis on cultural risk/stress factors.

HISPANIC ASSESSMENT WORKSHEETS FOR ADULTS

Client Name _____
Age _____
Date of Assessment _____

Domain 1. Discrimination Stress reflects problems faced as a result of having a different ethnic and cultural orientation.			
"Overall, how much stress do you or Your Family have related to Discrimination Problems?"	*High*	*Moderate*	*Not a problem*
If High or Moderate, Counselor Should Probe Further Using the Following Areas			
I have been discriminated against			
I experienced discrimination because of the color of my skin			
I was treated "less than" other Americans because I am Hispanic and Latino			
I was discriminated against because of my customs and cultural celebrations			
I have felt unaccepted by others due to my Hispanic culture			
Members of my family have experienced discrimination			
I was discriminated against in the health clinic or hospital			
I have seen friends treated badly because they are Hispanics/Latinos			
Because I am Hispanic and Latino, I have been paid less than others			
Because I am Hispanic and Latino, I was not expected to go to college			
I was arrested			

What resources area available for this youth?

How can resources be mobilized as part of the treatment plan?

Domain 2. Marital Stress reflects problems between couples, some of which may include different cultural values.			
"Overall, how much stress do you or your spouse have related to marital problems?"	*High*	*Moderate*	*Not a problem*
If High or Moderate, Counselor should probe further using the following areas			
I have felt that my spouse and I have not been able to communicate			
There is a lack of trust between my spouse and myself			
There was a lack of respect in our marital relationship			
My spouse and I have different personalities			
My spouse and I talked about divorce			
My spouse and I experienced infidelity			
My spouse and I disagreed about choosing our friends			
My spouse has been drinking too much alcohol			
My spouse and I disagreed on where we should live			
My spouse and I have disagreed on how to bring up our children			

What resources area available for this youth?

How can resources be mobilized as part of the treatment plan?

Domain 3. Health Stress reflects problems in available or accessible health care, including lack of culture appropriate care.			
"Overall, how much stress do you have related to Family Problems?"	*High*	*Moderate*	*Not a problem*
If High or Moderate, Counselor should probe further using the following areas			
I could not pay for my medical care			
We did not have health insurance to cover family medical issues			
I did not have access to high-quality health care			
I did not have health insurance to cover my illness			
I had to wait for a long time before I received health treatment			
I could not get dental insurance			

What resources area available for this youth?

How can resources be mobilized as part of the treatment plan?

Domain 4. Family Related Stress reflects family conflict, cultural based differences and low family unity.			
"Overall, how much stress do you have related to Family Problems?"	*High*	*Moderate*	*Not a Problem*
If High or Moderate, counselor should probe further using the following areas			
I had serious arguments with family members			
There have been conflicts among members of my family			
There has been physical violence among members of my family			
There was domestic violence in our home			
I have been around too much violence			
My personal goals have been in conflict with family goals			
Men in our family are too *macho* (jealous of women's accomplishments)			
There was no positive male figure in our family			

What resources area available for this youth?

How can resources be mobilized as part of the treatment plan?

Domain 5. Parental Stress reflects problems associated with cultural differences in parenting, differences in cultural orientation between parents and their children.			
"Overall, how much stress do you have related to Parenting Problems?"	*High*	*Moderate*	*Not a problem*
If High or Moderate, Counselor Should probe further using the following areas			
I have thought that my children used illegal drugs			
My children have been drinking alcohol			
My children have talked about leaving home			
My son or daughter became sexually active			
I have thought that my children wanted their independence before they are ready			
I had difficulties motivating my child about school			
My children have received bad school reports (or bad grades)			
I had arguments with my child about cultural values, customs, and morals			

What resources area available for this youth?

How can resources be mobilized as part of the treatment plan?

Domain 6. Occupational Stress reflects problems at work that may be related to one's culture or ethnicity.			
"Overall, how much stress do you have related to your work or job?"	*High*	*Moderate*	*Not a problem*
If High or Moderate, Counselor Should Probe Further Using the Following Areas			
Others have been too worried about the amount and quality of work I do			
I have been criticized about my work			
I have had to watch the quality of my work so others do not think I am lazy			
My boss has thought of me as being too passive			
Because of the importance of getting ahead in my job, I had to compete with others			

What resources area available for this youth?

How can resources be mobilized as part of the treatment plan?

Domain 7. Unemployment and Economic Stress reflects problems with employment, financial stress and overall poor economic conditions.			
"Overall, how much stress do you have related to your economic conditions or being unemployed?"	*High*	*Moderate*	*Not a problem*
If High or Moderate, counselor should probe further using the following areas			
I lost my job			
I could not find a job			
I have been forced to accept low paying jobs			
My income has not been sufficient to support my family or myself			

What resources area available for this youth?

How can resources be mobilized as part of the treatment plan?

Domain 8. Immigration Stress includes problems associated with legal status, deportation and social isolation.			
"Overall, how much stress do you have related to immigration issues?"	*High*	*Moderate*	*Not a Problem*
If High or Moderate, counselor should probe further using the following areas			
My legal status has been a problem in getting a good job.			
I fear the consequences of deportation.			
I have thought that if I went to a social or government agency I would be deported.			
Because I did not have a SSN, I could not apply for or find good employment.			
My legal status has limited my contact with family and friends.			
I have been questioning about my legal status.			
Since I did not legal documentation, I was overworked at my job.			
Because my lack of legal documentation, I could not get quality health care.			
Because I did not have driver's license it was difficult to get to and from work.			

What resources area available for this youth?

How can resources be mobilized as part of the treatment plan?

VIII. Conclusions

The need to reduce the mental health disparity gaps in the Hispanic population through the use of accurate early detection and screening assessments for both youth and adults has been well documented. Research on the development of Hispanic specific assessment tools has lagged far behind the general research in this area. Moreover, much of the development has been limited to translation (and test adaptation) of current existing objective assessments, inappropriate use of white non-Hispanic norm or reference groups, and lack of establishing validity for use with the Hispanic population. There are no readily available and accessible Hispanic-based assessment tools for use in screening, diagnosis or treatment planning efforts. Not to take into account factors embedded within the Hispanic experience that mediate mental health (e.g., acculturation, language use, citizenship status), arguably, can result in a risk of misdiagnosis, inappropriate treatment, and premature termination (Cervantes & Bui, 2015; Prieto, McNeil, Walls, & Gómez, 2001). This is remarkable given the growing Hispanic population and their need for behavioral health services.

This Guide provides a qualitative interview based approach to assessment based on validated quantitative assessment research. Having the tools necessary to increase the ability of counselors to assess stress and risk factors is an important aspect of providing culturally competent care. Counselor must be more mindful of the cultural stressors and risk factors that are known to be related to mental health and substance use problems. In turn, increased counselor awareness of cultural stress and risk factors can assist in tailoring treatments that clearly address underlying cultural conflict and can also help clients develop resilience and coping skills to address these cultural issues.

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